VITALIA HEALTH CARE

PATIENT PROFILE

Date: _____ Full Name: _____

Birthdate: _____ Age: _____ Gender: ☐ Male ☐ Female

Address: _____

_____Email address: _____

Phone # (Primary): _____ Phone # (Secondary): _____

Primary Physician: _____ Physician phone #: _____

Mother's name and Phone number: _____

Father's name and Phone number: _____

Known Allergies (Foods, Drugs, Vaccines, or Environmental): _____

_____

How did you hear about our clinic? _____

At what age was your child diagnosed with Autism or ADHD? _____

What age did symptoms become apparent? _____

Please list any other diagnosis or health concerns:

1) _____

2) _____

3) _____

4 _____

Current Medications (Prescription, Over The Counter Drugs, Vitamins, Herbs, Homeopathic Remedies, Etc.)

1)_____ Dosage _____ 6)_____ Dosage _____

2)_____ Dosage _____ 7)_____ Dosage _____

3)_____ Dosage _____ 8)_____ Dosage _____

4)_____ Dosage _____ 9)_____ Dosage _____

5)_____ Dosage _____ 10)_____ Dosage _____

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Hospitalization (when, for what, and how long):

_____

_____

Development:

What age did your child start to talk? _____

Did your child's speech regress? _____ If yes, what age? _____

Was your child breastfed? _____ If yes, how long? _____

DIET

Describe your child's average meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

List foods that they crave: _____

Describe any diet restrictions or regimens that they follow: _____

How many glasses of water does your child drink per day? _____

Is child a picky eater? Y N

Average hours of sleep per night: _____ Do you give pills or herbs to help sleep? ☐ No ☐ Yes

Does your child have difficulty sleeping? ☐ Daily ☐ Often ☐ Sometimes ☐ Never

FAMILY HISTORY

Do you have any other children with Autism or ADHD? _____

REVIEW OF SYSTEMS

For each of the following symptoms/illnesses, please circle the appropriate letter or fill in the information.

Y = Presently Have **P = Had In The Past** **N = Never Had**

General			
Allergies	Y	P	N
Night Sweat	Y	P	N
Weakness or lethargy	Y	P	N

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Gastrointestinal				
Bad breath	Y	P	N	
Loose stool	Y	P	N	
Too much gas	Y	P	N	
Abdominal pain	Y	P	N	
Fatty food intolerance	Y	P	N	
Constipation	Y	P	N	
Diarrhea	Y	P	N	
Understanding/Awareness				
Limited understanding	Y	P	N	
Follows commands	Y	P	N	
Normal understanding for age	Y	P	N	
Play Skills				
Appropriate for age	Y	P	N	
Repetitive	Y	P	N	
Pretend/Imaginative play	Y	P	N	
Motor Skills				
Delayed gross motor (climbing, running)	Y	P	N	
Delayed fine motor (writing)	Y	P	N	
Uncoordinated/clumsy	Y	P	N	
Toe walking	Y	P	N	
Growth Delays	Y	P	N	
Frequent Infections	Y	P	N	**Se**
Hypothyroidism	Y	P	N	
Muscle weakness	Y	P	N	
Poor endurance	Y	P	N	**COQ**
Low muscles tone	Y	P	N	
Low energy	Y	P	N	
Fatigue	Y	P	N	
Poor endurance	Y	P	N	
Difficulty warming up	Y	P	N	
Craves salt	Y	P	N	**Fe**
Spoon-shaped nails	Y	P	N	
Lower IQ	Y	P	N	
Pale Skin	Y	P	N	
Depression	Y	P	N	
Weakness and Fatigue	Y	P	N	
Irritability	Y	P	N	**Folate**
Headaches	Y	P	N	

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Low infant birth weight	Y	P	N	
Preterm delivery	Y	P	N	
Poor growth	Y	P	N	
Low IQ	Y	P	N	
Red swollen tongue	Y	P	N	
Cracks on side of tongue	Y	P	N	**B6**
dandruff	Y	P	N	
eczema	Y	P	N	
Microcytic anemia	Y	P	N	
Mood/behavioral problems	Y	P	N	
Anxiety	Y	P	N	
Teeth grinding	Y	P	N	
Aggression	Y	P	N	
Hyperactivity	Y	P	N	
Poor endurance	Y	P	N	**Mg**
Stimming	Y	P	N	
Constipation	Y	P	N	
Poor memory	Y	P	N	
Learning problems	Y	P	N	
Sound/light sensitivity	Y	P	N	
Dermatitis	Y	P	N	
Eczema	Y	P	N	
Dandruff	Y	P	N	
Thrush	Y	P	N	**Fungal**
Cradle cap	Y	P	N	**Biotin**
Red cheeks	Y	P	N	
Silly, goofy behavior	Y	P	N	
Toe-walking	Y	P	N	
Poor growth of hair	Y	P	N	
Bloated abdomen	Y	P	N	
Gas	Y	P	N	
Reflux	Y	P	N	**ProBio**
Diarrhea	Y	P	N	
History of infections (ear, colds)	Y	P	N	
Scaly skin	Y	P	N	
Dry eyes	Y	P	N	
Vision problems	Y	P	N	
Picky appetite especially for vegetables	Y	P	N	

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Sensory seeking or averse	Y	P	N	**Zn**
White lines on fingernails	Y	P	N	
Skin rashes	Y	P	N	
Acne	Y	P	N	
Eczema	Y	P	N	
Dermatitis	Y	P	N	
Frequent infections	Y	P	N	
Canker sores	Y	P	N	
Insomnia (if yes, difficulties falling asleep or staying asleep)	Y	P	N	
Wakes up crying and/or screaming	Y	N		
Wakes up laughing and/or playing	Y	N		

MOTHER'S PREGNANCY AND LABOUR

Was your child delivered: Vaginal _____ C-section _____ Forceps _____ Suction used _____
Was birth premature Y N If Yes, at how many weeks _____
Is child a twin? Y N
Any birth trauma? Y N
Describe _____
Complications/infections of baby? _____

VACCINATIONS

Has child received all recommended vaccinations for their age? Y N
If no, has child received any of the following (check):
DPT ___ HIB ___ Hep B ___ Polio ___ MMR ___ Pneumococcal ___ Varicella ___ Meningococcal ___
Flu shot ___ H1N1 ___

Did your child receive any vaccinations when they were sick? Y N
Did your child have any vaccine reactions:
Fever ___ (circle) – Mild or High Rash ___ Seizures ___ Excessive fatigue ___ Vomiting ___
Swelling at injection site ___ Behavior change ___ Irritability/screaming ___ Loss of eye contact/speech ___